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Health Reports

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Preface

Health Reports is a list of reports and testimonies issued by the General Accounting Office (GAO) over the past 2 years. Organized chronologically, the entries provide a title, report number, and issue date for each GAO health product. Reports and testimonies on the same topic may be combined into a single entry.

The first section—Recent GAO Products—summarizes reports and testimonies on selected health issues published from November 1991 through June 1992. The summaries are followed by a list of additional products published during the same period. The remainder of Health Reports is a list of health products published from June 1990 through June 1992 organized by subject areas as shown in the table of contents. As appropriate, entries have been cross-indexed and are included in more than one subject area. An order form to be placed on our mailing list for Health Reports is on page 36 of this report. An order form to request GAO products is on page 37.

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Abbreviations

ADMS	Alcohol, Drug Abuse and Mental Health Services
ADP	automatic data processing
AIDS	acquired immunodeficiency syndrome
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense
ERISA	Employee Retirement Income Security Act of 1974
FDA	Food and Drug Administration
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHA	home health agency
HHS	Department of Health and Human Services
HMO	health maintenance organization
MSP	Medicare secondary payer
NAIC	National Association of Insurance Commissioners
OSIJA	Occupational Safety and Health Administration
PRO	peer review organization
VA	Department of Veterans Affairs
WIC	Special Supplemental Food Program for Women, Infants, and Children

Recent GAO Products

(Nov. 1991 - June 1992)

Summaries of Selected Reports

Access to Health Care: States Respond to Growing Crisis (June 16, 1992, GAO/HRD-92-70).

States have taken a leadership role in devising strategies to expand access to health insurance and contain the growth of health costs. A difficult hurdle to overcome, however, is the restrictions imposed by the preemption clause of the Employee Retirement Income Security Act of 1974 (ERISA). This clause effectively prevents states from exercising control over all employer-provided insurance. Hawaii is the only state with an exemption, in part because its law requiring employer-provided health insurance took effect before ERISA was enacted. Other states have tried to move toward coverage of all their citizens within ERISA's constraints. Some state initiatives have been more narrowly focused, creating programs to assist specific groups. State budgetary constraints, however, have limited these programs to serving a small fraction of the uninsured population.

Screening Mammography: Federal Quality Standards Are Needed (June 5, 1992, GAO/T-HRD-92-39).

GAO reported in Screening Mammography: Low-Cost Services Do Not Compromise Quality (Jan. 10, 1990, GAO/HRD-90-32) that many screening mammography providers surveyed lacked the quality assurance programs needed to ensure safe and accurate mammograms for women. GAO also identified a need for strong federal standards to assure quality of screening mammography. The Congress required the Secretary of Health and Human Services (HHS) to establish quality standards for mammography providers serving the Medicare population. Of significant concern, however, are the 30 million women not eligible for Medicare who should obtain regular screening and are not necessarily protected by federal quality standards.

Federally Funded Health Services: Information on Seven Programs Serving Low-Income Women and Children (May 28, 1992, GAO/HRD-92-73FS).

This fact sheet provides information on services, eligibility, and program interrelationships for seven programs that fund the delivery of health services to low-income women and children. The programs are the Preventive Health and Health Services block grant; Maternal and Child Health block grant; Early and Periodic Screening, Diagnosis, and Treatment portion of Medicaid; Childhood Immunization Program; Childhood Lead Poisoning Prevention; Community Health Centers; and Migrant Health Centers. GAO found that requirements for inter-program coordination were not well defined.

Medicare: Excessive Payments Support the Proliferation of Costly Technology (May 27, 1992, GAO/HRD-92-59).

In some localities, Medicare's technical component payments for Magnetic Resonance Imaging do not reflect the lower costs per scan now being achieved through faster scanning and greater machine utilization. This is because current payment levels are based, in part, on the charges allowed by local Medicare contractors in the mid-1980s. The 1991 payment levels in some localities were more than twice as high as in others, reflecting wide geographic disparities in the historical allowed charges. Medicare should base its payments on the costs incurred by high-volume, efficient facilities to reduce program expenditures and to discourage providers from adding excess capacity to the health care system.

Contractor Oversight and Funding Need Improvement (May 21, 1992, GAO/T-HRD-92-32).

GAO's work in recent years suggests that the Health Care Financing Administration (HCFA) may need to exercise more active oversight over its contractors. Investigations into allegations of fraud and abuse and recovery of mistaken payments have not been adequate. Funding for Medicare's program safeguards has not kept pace with the growth in claims volume. GAO believes that HCFA must take a more active stance to hold contractors accountable for their performance in program administration.

Long-Term Care Insurance: Better Controls Needed to Protect Consumers (May 20, 1992, GAO/HRD-92-31). Testimony on same topic (May 20, 1992, GAO/T-HRD-92-31).

GAO found that despite National Association of Insurance Commissioners (NAIC) standards, consumers are still vulnerable to considerable risks in purchasing long-term care insurance. Consumers are at risk because (1) many states have not adopted key NAIC standards, including some developed between 1986 and 1988, and (2) the NAIC standards do not sufficiently address several features of long-term care insurance, such as policy terminology, definitions, and eligibility criteria, that have important consequences for consumers. GAO believes that additional standards are necessary which, among other things, promote uniform terminology and definitions, establish guidelines that address the relevance of eligibility criteria to different types of impairments, and establish formal grievance procedures.

Access to Health Insurance: States Attempt to Correct Problems in Small Business Health Insurance Market (May 14, 1992, GAO/HRD-92-90). Testimony on same topic (May 14, 1992, GAO/T-HRD-92-30).

GAO found that most states have proposed or already implemented programs to try to expand small business employees' access to health insurance coverage. Many of these initiatives have been adopted within the past 2 years, but the early indications are that they have led to only modest gains in the number of firms offering health insurance. This is largely because costs have not been reduced sufficiently to induce small firms to offer health insurance.

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (May 7, 1992, GAO/HRD-92-69). Testimony on same topic (May 7, 1992, GAO/T-HRD-92-29).

Weaknesses within the health insurance system allow unscrupulous health care providers to cheat insurance companies and programs out of billions of dollars annually. Repairing the system's weaknesses presents a dilemma to policymakers: on the one hand, safeguards must be adequate for prevention, detection, and pursuit; on the other, they must not be unduly burdensome or intrusive for policyholders, providers, insurers, and law enforcement officials. GAO has asked the Congress to consider establishing a national health care fraud commission as a way to unite the efforts of public and private payers and to build consensus among representatives of divergent viewpoints.

VA Health Care: The Quality of Care Provided by Some VA Psychiatric Hospitals Is Inadequate (Apr. 22, 1992, GAO/HRD-92-17).

In fiscal year 1990, VA spent approximately \$1.3 billion to operate and maintain its mental health care programs and facilities. None of the four VA psychiatric hospitals GAO visited are effectively collecting and using quality assurance data on a consistent basis to identify and resolve quality-of-care problems in the psychiatric and medical care they are providing. GAO recommends that the Secretary of Veterans Affairs require the Chief Medical Director to: (1) define treatment goals, provide guidance on the evaluation of these goals, and ensure program reviews to evaluate the attainment of the goals; and (2) hold each hospital director responsible for making certain that identified medical and psychiatric quality-of-care problems are thoroughly examined and corrective actions are taken.

Home Health Care: HCFA Evaluation of Community Health Accreditation Program Inadequate (Apr. 20, 1992, GAO/HRD-92-93).

GAO evaluated HCFA's proposed regulation that governs the review of accrediting organizations. GAO found that HCFA's evaluation of the Community Health Accreditation Program's ability to assure that home health agencies adhere to Medicare conditions of participation was inadequate. Moreover, several areas cited in HCFA's proposed regulation governing the deeming of accrediting organizations were not effectively evaluated.

Medicaid: Factors to Consider in Expanding Managed Care Programs (Apr. 10, 1992, GAO/T-HRD-92-26).

Medicaid is being severely strained by the continued rise in the size of its population and cost. Federal and state policymakers are turning to managed care as a possible way to obtain better access to higher quality services for the money spent. Preliminary results from our review of the Oregon managed care program indicate that previously identified problems in Chicago health maintenance organizations that involve access to care, service quality, provider disclosure, provider solvency, and provider oversight can be lessened through appropriate oversight and adequate safeguards. Client advocates give the Oregon program high marks.

Early Intervention: Federal Investments Like wic Can Produce Savings (Apr. 7, 1992, GAO/HRD-92-18).

When the value of prevention is not quantified, legislators cannot easily factor it into their budgetary decisionmaking. To help quantify the value of prevention, GAO developed and tested a framework to analyze the costs and benefits associated with early intervention efforts. Using the Special Supplemental Food Program for Women, Infants, and Children (wic) as a test case, GAO concludes that providing wic benefits to pregnant women more than pays for itself within a year. GAO also found that the formula used to distribute wic funds to the states does not adequately consider the number of eligible persons in states.

Health Care: Problems and Potential Lessons for Reform (Mar. 27, 1992,
GAO/T-HRD-92-23).

Rapidly growing costs and inaccessibility of health care for a growing share of our population have generated a consensus that the U.S. health care system needs significant change. The challenge is to find a better way to manage and finance the U.S. system while preserving high-quality, innovative medical care. GAO work suggests that common themes in successful health care programs include (1) universal coverage, (2) a uniform system for managing payment of providers, and (3) expenditure targets or caps for major categories of providers and services. GAO is beginning to assess the health care system in the Rochester, New York, which appears to be more successful than most in controlling the twin problems of rapidly rising costs and constricting access to health insurance.

Long-Term Care Insurance: Better Controls Needed in Sales to People With Limited Financial Resources (Mar. 27, 1992, GAO/HRD-92-66).

Long-term care insurance is expensive. People with limited financial resources should not buy it because many are eligible for government assistance. In fact, both health and financial factors limit the number of older people able to purchase long-term care insurance. Our work at eight insurance companies found that, except for Medicaid recipients, companies are doing little to prevent the sale of long-term care insurance to low-income people. Officials from these companies told us that their policy is to avoid selling this insurance to low-income people. However, this policy is not always articulated in writing, and companies' actual practices are difficult to determine. Despite their stated intentions, the companies have few controls over sales of long-term care insurance.

Medicare: Over \$1 Billion Should Be Recovered From Primary Health Insurers (Feb. 21, 1992, GAO/HRD-92-52).

Medicare contractors have significant backlogs of mistaken payments for Medicare beneficiaries that are unrecovered from primary health insurers. Medicare contractors recently surveyed by HCFA reported backlogs of over \$1 billion in Medicare that were mistakenly paid. These backlogs could increase as a result of (1) a recently initiated HCFA effort to identify additional primary insurers, and (2) contractors' research of previously paid beneficiary claims. Millions of dollars may be lost due to a HHS regulation that limits the time a contractor has to initiate recovery on a claim after it identifies a primary insurer. Collections of Medicare

secondary payer (MSP) program mistaken payments far exceed carriers' cost of recovery. Medicare contractors advised HCFA that inadequate MSP funding is the reason for backlogs of mistaken payments.

Health Care Spending: Nonpolicy Factors Account for Most State Differences (Feb. 13, 1992, GAO/HRD-92-36).

In most states, per capita spending on personal health care is near the U.S. average of \$2,255 per capita in 1990. Many states with higher spending levels are concentrated in the Northeast, Midwest, and Far West, while many states with lower per capita spending are in the South and Rocky Mountain regions. Differences among states result largely from factors that state governments can do little to control. Most state differences in per capita personal health spending result from variations in personal income, health care services' capacity (including the number of physicians and hospital and nursing home beds), the concentration of hospital services in urban areas, and health status.

VA Health Care for Women: Despite Progress, Improvements Needed (Jan. 23, 1992, GAO/HRD-92-23).

VA has made significant progress since 1982 toward ensuring that female veterans have access to health care equal to that of male veterans. However, some problems remain in caring for women veterans. Physical examinations, including cancer screening, continue to be sporadic. VA medical centers are inadequately monitoring in-house mammography programs to ensure compliance with American College of Radiology quality standards.

Medical Malpractice: Alternatives to Litigation (Jan. 10, 1992, GAO/HRD-92-28).

Arbitration and no-fault programs are alternatives to litigation. Fifteen states have specific statutes on medical malpractice arbitration. Virginia and Florida enacted statutes authorizing no-fault programs to resolve certain birth-related injury claims. Michigan is the only state that (1) has a method to make patients aware of the arbitration option and (2) established a program to implement its statute's requirements. But even in Michigan, relatively few malpractice claims have been filed for arbitration compared with those filed for litigation. At least two private sector HMOs, covering over 6 million enrollees, have mandated the use of arbitration to resolve malpractice claims. Also, a demonstration project in Maine has

established standards of care in four specialties. Starting in 1992, those participating physicians who follow the standards may be protected from litigation. However, Maine officials expect the legality of the approach to be challenged.

Health Care Spending Control: The Experience of France, Germany, and Japan (Nov. 15, 1991, GAO/HRD-92-9). French and German translations available (Nov. 15, 1991, GAO/HRD-92-9ES). Testimony on same topic (Nov. 19, 1991, GAO/T-HRD-92-12).

France, Germany, and Japan achieve near-universal health insurance coverage. This report describes these countries' health insurance and financing methods, their policies intended to restrain health care spending increases, and the effectiveness of these policies. Although GAO does not endorse the specific health systems in the reviewed countries, their strengths and weaknesses could be instructive in helping resolve U.S. health care problems.

list of Additional GAO Health Products

VA Health Care: Copayment Exemption Procedures Should Be Improved (June 1992, GAO/HRD-92-77).

VA Health Care: Delays in Awarding Major Construction Contracts (June 11, 1992, GAO/HRD-92-111).

Financial Reporting: Accounting for the Postal Service's Postretirement Health Care Costs (May 20, 1992, GAO/AFMD-92-32).

Occupational Safety & Health: Worksite Safety and Health Programs Show Promise (May 19, 1992, GAO/HRD-92-68). Testimony on same topic (Feb. 26, 1992, GAO/T-HRD-92-15).

Occupational Safety & Health: Employers' Experiences in Complying With the Hazard Communication Standard (May 8, 1992, GAO/HRD-92-63BR).

Pharmaceutical Industry: Tax Benefits of Operating in Puerto Rico (May 4, 1992, GAO/GGD-92-72BR).

University Research: Controlling Inappropriate Access to Federally Funded Research Results (May 4, 1992, GAO/RCED-92-104).

Defense Health Care: Efforts to Manage Mental Health Care Benefits to CHAMPUS Beneficiaries (Apr. 28, 1992, GAO/T-HRD-92-27).

Over the Counter Drugs: Gaps and Potential Vulnerabilities in the Regulatory System (Apr. 28, 1992, GAO/T-PEMD-92-8). Report on same topic (Jan. 10, 1992, GAO/PEMD-92-9).

Drug Control: Difficulties in Denying Federal Benefits to Convicted Drug Offenders (Apr. 21, 1992, GAO/GGD-92-56).

Social Security: Racial Difference in Disability Decisions Warrants Further Investigation (Apr. 21, 1992, GAO/HRD-92-56).

FDA Premarket Approval: Process of Approving Olestra as a Food Additive (Apr. 7, 1992, GAO/HRD-92-86).

FDA Premarket Approval: Process of Approving Ansaid as a Drug (Apr. 7, 1992, GAO/HRD-92-85).

Federal Workforce: Agencies' Procurements of Private Health Club Services (Apr. 7, 1992, GAO/GGD-92-66).

Defense Health Care: Obstacles in Implementing Coordinated Care (Apr. 7, 1992, GAO/T-HRD-92-24).

Maternal and Child Health: Block Grant Funds Should be Distributed More Equitably (Apr. 2, 1992, GAO/HRD-92-5).

FDA Regulations: Sustained Management Attention Needed to Improve Timely Issuance (Apr. 1, 1992, GAO/T-HRD-92-19). Report on same topic (Feb. 21, 1992, GAO/HRD-92-35).

Health Care: Readiness of U.S. Contingency Hospital Systems to Treat War Casualties (Mar. 25, 1992, GAO/T-HRD-92-17).

Medical Technology: Implementing the Good Manufacturing Practices Regulations (Mar. 25, 1992, GAO/T-PEMD-92-6). Report on same topic (Feb. 13, 1992, GAO/PEMD-92-10).

Community Health Centers: Administration of Grant Awards Needs Strengthening (Mar. 18, 1992, GAO/HRD-92-51).

Medicare: Shared Systems Policy Inadequately Planned and Implemented
(Mar. 18, 1992, GAO/IMTEC-92-41). Testimony on same topic (Mar. 18, 1992, GAO/T-IMTEC-92-11).

Cross Design Synthesis: A New Strategy for Medical Effectiveness Research (Mar. 17, 1992, GAO/PEMD-92-18).

Board and Care Homes: Medication Mishandling Places Elderly at Risk
(Mar. 13, 1992, GAO/T-HRD-92-16). Report on same topic (Feb. 7, 1992, GAO/HRD-92-45).

Small Group Market Reforms: Assessment of Proposals to Make Health Insurance More Readily Available to Small Businesses (Mar. 12, 1992, GAO/HRD-92-27R).

Cancer Treatment: Efforts to More Fully Utilize the Pacific Yew's Bark
(Mar. 4, 1992, GAO/T-RCED-92-36).

Medicare: Payments for Medically Directed Anesthesia Services Should be Reduced (Mar. 3, 1992, GAO/HRD-92-25).

Medigap Insurance: Insurers Whose Loss Ratios Did Not Meet Federal Minimum Standards in 1988-89 (Feb. 28, 1992, GAO/HRD-92-54).

VA Health Care: VA Plans Will Delay Establishment of Hawaii Medical Center (Feb. 25, 1992, GAO/HRD-92-41).

Hired Farmworkers: Health and Well-Being at Risk (Feb. 14, 1992, GAO/HRD-92-46).

Federal Health Benefits Program: Stronger Controls Needed to Reduce Administrative Costs (Feb. 12, 1992, GAO/GGD-92-27).

Drug Education: Rural Programs Have Many Components and Most Rely Heavily on Federal Funds (Jan. 31, 1992, GAO/HRD-92-34).

Medicare: Rationale for Higher Payment for Hospital-Based Home Health Agencies (Jan. 31, 1992, GAO/HRD-92-24).

Medicare: Third Status Report on Medicare Insured Group Demonstration Projects (Jan. 29, 1992, GAO/HRD-92-53).

VA Health Care: Modernizing VA's Mail-Service Pharmacies Should Save Millions of Dollars (Jan. 22, 1992, GAO/HRD-92-30).

Adolescent Drug Use Prevention: Common Features of Promising Community Programs (Jan. 16, 1992, GAO/PEMD-92-2).

International Environment: Kuwaiti Oil Fires—Chronic Health Risks Unknown but Assessments Are Under Way (Jan. 16, 1992, GAO/RCED-92-80BR).

Budget Issues: 1991 Budget Estimates: What Went Wrong (Jan. 15, 1992, GAO/OCG-92-1).

Hispanic Access to Health Care: Significant Gaps Exist (Jan. 15, 1992, GAO/PEMD-92-6). Testimony on same topic (Sept. 19, 1991, GAO/T-PEMD-91-13).

Drug Abuse Research: Federal Funding and Future Needs (Jan. 14, 1992, GAO/PEMD-92-5). Testimony on same topic (Sept. 25, 1991, GAO/PEMD-T-91-14).

Defense Health Care: Efforts to Address Health Effects of the Kuwait Oil Well Fires (Jan. 9, 1992, GAO/HRD-92-50).

Defense Health Care: Transfers of Military Personnel With Disabled Children (Jan. 9, 1992, GAO/HRD-92-15).

Long-Term Care Insurance: Risks to Consumers Should Be Reduced (Dec. 26, 1991, GAO/HRD-92-14). Testimony on same topic (Apr. 11, 1991, GAO/T-HRD-91-14).

Aging Issues: Related GAO Reports and Activities in Fiscal Year 1991 (Dec. 17, 1991, GAO/HRD-92-57).

VA Health Care: Compliance With Joint Commission Accreditation Requirements is Improving (Dec. 13, 1991, GAO/HRD-92-19).

Breast Cancer, 1971-91: Prevention, Treatment, and Research (Dec. 11, 1991, GAO/PEMD-92-12). Testimony on same topic (Dec. 11, 1991, GAO/T-PEMD-92-4).

Medical Residents: Options Exist to Make Student Loan Payments Manageable (Nov. 26, 1991, GAO/HRD-92-21).

Occupational Safety & Health: OSHA Action Needed to Improve Compliance With Hazard Communication Standard (Nov. 26, 1991, GAO/HRD-92-8).

Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (Nov. 12, 1991, GAO/HRD-92-11). Testimony on same topic (Nov. 15, 1991, GAO/T-HRD-92-11).

Defense Health Care: CHAMPUS Mental Health Benefits Greater Than Those Under Other Health Plans (Nov. 7, 1991, GAO/HRD-92-20).

Medicare: Effect of Durable Medical Equipment Fee Schedules on Six Suppliers' Profits (Nov. 6, 1991, GAO/HRD-92-22).

Significant Reductions in Corporate Retiree Health Liabilities Projected if Medicare Eligibility Age Lowered to 60 (Nov. 5, 1991, GAO/T-HRD-92-7).

Occupational Safety & Health: Worksite Programs and Committees (Nov. 5, 1991, GAO/T-HRD-92-9).

Health Financing and Access

Access to Health Care: States Respond to Growing Crisis (June 16, 1992, GAO/HRD-92-70).

Federally Funded Health Services: Information on Seven Programs Serving Low-Income Women and Children (May 28, 1992, GAO/HRD-92-73FS).

Access to Health Insurance: States Attempt to Correct Problems in Small Business Health Insurance Market (May 14, 1992, GAO/HRD-92-90). Testimony on same topic (May 14, 1992, GAO/T-HRD-92-30).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (May 7, 1992, GAO/HRD-92-69). Testimony on same topic (GAO/T-HRD-92-29).

Early Intervention: Federal Investments Like wic Can Produce Savings (Apr. 7, 1992, GAO/HRD-92-18).

Maternal and Child Health: Block Grant Funds Should Be Distributed More Equitably (Apr. 2, 1992, GAO/HRD-92-5).

Health Care: Problems and Potential Lessons for Reform (Mar. 27, 1992, GAO/T-HRD-92-23).

Small Group Market Reforms: Assessment of Proposals to Make Health Insurance More Readily Available to Small Businesses (Mar. 12, 1992, GAO/HRD-92-27R).

Medigap Insurance: Insurers Whose Loss Ratios Did Not Meet Federal Minimum Standards in 1988-89 (Feb. 28, 1992, GAO/HRD-92-54).

Health Care Spending: Nonpolicy Factors Account for Most State Differences (Feb. 13, 1992, GAO/HRD-92-36).

Federal Health Benefits Program: Stronger Controls Needed to Reduce Administrative Costs (Feb. 12, 1992, GAO/GGD-92-27).

Budget Issues: 1991 Budget Estimates: What Went Wrong (Jan. 15, 1992, GAO/OCG-92-1).

Hispanic Access to Health Care: Significant Gaps Exist (Jan. 15, 1992, GAO/PEMD-92-6). Testimony on same topic (Sept. 19, 1991, GAO/T-PEMD-91-13).

Health Care Spending Control: The Experience of France, Germany, and Japan (Nov. 15, 1991, GAO/HRD-92-9). French and German translations available (Nov. 15, 1991, GAO/HRD-92-9ES). Testimony on same topic (Nov. 19, 1991, GAO/T-HRD-92-12).

Off-Label Drugs: Reimbursement Policies Constrain Physicians in Their Choice of Cancer Therapies (Sept. 27, 1991, GAO/PEMD-91-14).

States Need More Department of Labor Help to Regulate Multiple Employer Welfare Arrangements and Correct Problems (Sept. 17, 1991, GAO/T-HRD-91-47).

Managed Care: Oregon Program Appears Successful but Expansion Should Be Implemented Cautiously (Sept. 16, 1991, GAO/T-HRD-91-48).

Rural Hospitals: Closures and Issues of Access (Sept. 4, 1991, GAO/T-HRD-91-46).

Nonprofit Hospitals: Better Standards Needed for Tax Exemption (July 10, 1991, GAO/T-HRD-91-43). Report on same topic (May 30, 1990, GAO/HRD-90-84).

Private Health Insurance: Problems Caused by a Segmented Market (July 2, 1991, GAO/HRD-91-114). Testimony on same topic (May 2, 1991, GAO/T-HRD-91-21).

U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform (June 10, 1991, GAO/HRD-91-102). French and German translations available (June 10, 1991, GAO/HRD-91-102). Testimony on same topic (Apr. 17, 1991, GAO/T-HRD-91-16).

Canadian Health Insurance: Lessons for the United States (June 4, 1991, GAO/HRD-91-90). Testimony on same topic (June 4, 1991, GAO/T-HRD-91-35).

Trauma Care: Lifesaving System Threatened by Unreimbursed Costs and Other Factors (May 17, 1991, GAO/HRD-91-57).

Retiree Health: Company-Sponsored Plans Facing Increased Costs and Liabilities (May 6, 1991, GAO/T-HRD-91-25).

Workers at Risk: Increased Numbers in Contingent Employment Lack Insurance, Other Benefits (Mar. 8, 1991, GAO/HRD-91-56).

Medigap Insurance: Better Consumer Protection Should Result From 1990 Changes to Baucus Amendment (Mar. 5, 1991, GAO/HRD-91-49).

Rural Hospitals: Federal Efforts Should Target Areas Where Closures Would Threaten Access to Care (Feb. 15, 1991, GAO/HRD-91-41).

Health Insurance Coverage: A Profile of the Uninsured in Selected States (Feb. 8, 1991, GAO/HRD-91-31FS).

Home Visiting: A Promising Early Intervention Service Delivery Strategy (Oct. 2, 1990, GAO/T-HRD-91-2). Report on same topic (July 11, 1990, GAO/HRD-90-83).

Budget Issues: Effects of the Fiscal Year 1990 Sequester on the Department of Health and Human Services (Aug. 9, 1990, GAO/HRD-90-158FS).

Rural Hospitals: Factors That Affect Risk of Closure (June 19, 1990, GAO/HRD-90-134).

Rural Hospitals: Federal Leadership and Targeted Programs Needed (June 12, 1990, GAO/HRD-90-67).

Medicare and Medicaid

Medicare: Excessive Payments Support the Proliferation of Costly Technology (May 27, 1992, GAO/HRD-92-59).

Contractor Oversight and Funding Need Improvement (May 21, 1992, GAO/T-HRD-92-32).

Medicaid: Factors to Consider in Expanding Managed Care Programs (Apr. 10, 1992, GAO/T-HRD-92-26).

Medicare: Shared Systems Policy Inadequately Planned and Implemented (Mar. 18, 1992, GAO/IMTEC-92-41). Testimony on same topic (Mar. 18, 1992, GAO/T-IMTEC-92-11).

Medicare: Payments for Medically Directed Anesthesia Services Should Be Reduced (Mar. 3, 1992, GAO/HRD-92-25).

Medicare: Over \$1 Billion Should Be Recovered From Primary Health Insurers (Feb. 21, 1992, GAO/HRD-92-52).

Medicare: Rationale for Higher Payment for Hospital-Based Home Health Agencies (Jan. 31, 1992, GAO/HRD-92-24).

Medicare: Third Status Report on Medicare Insured Group Demonstration Projects (Jan. 29, 1992, GAO/HRD-92-53).

Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (Nov. 15, 1991, GAO/T-HRD-92-11). Report on same topic (Nov. 12, 1991, GAO/HRD-92-11).

Medicare: Effect of Durable Medical Equipment Fee Schedules on Six Suppliers' Profits (Nov. 6, 1991, GAO/HRD-92-22).

Significant Reductions in Corporate Retiree Health Liabilities Projected If Medicare Eligibility Age Lowered to 60 (Nov. 5, 1991, GAO/T-HRD-92-7).

Medicare: Millions of Dollars in Mistaken Payments Not Recovered (Oct. 21, 1991, GAO/HRD-92-26).

Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (Oct. 2, 1991, GAO/HRD-92-1). Testimony on same topic (Oct. 2, 1991, GAO/T-HRD-92-2).

Medicaid: Changes in Drug Prices Paid by VA and DOD Since Enactment of Rebate Provisions (Sept. 18, 1991, GAO/HRD-91-139).

Health Care: Actions to Terminate Problem Hospitals From Medicare Are Inadequate (Sept. 5, 1991, GAO/HRD-91-54).

Medicare: Information Needed to Assess Payments to Providers (Aug. 8, 1991, GAO/HRD-91-113).

Medicaid Expansions: Coverage Improves but State Fiscal Problems Jeopardize Continued Progress (June 25, 1991, GAO/HRD-91-78).

Substance Abuse Treatment: Medicaid Allows Some Services but Generally Limits Coverage (June 13, 1991, GAO/HRD-91-92).

Medicare: Further Changes Needed to Reduce Program Costs (June 13, 1991, GAO/T-HRD-91-34). Report on same topic (May 15, 1991, GAO/HRD-91-67).

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